

Please Print Plainly
SHADED AREAS FOR
LAB USE ONLY

State of Washington
DEPARTMENT OF HEALTH
1610 N.E. 150th ST., Seattle, Washington 98155-7224

MYCOBACTERIOLOGY

13		COUNTY-CITY (8-10)		(11-14)		DATE SPECIMEN OBTAINED (15-20) MONTH DAY YEAR	
DATE RECEIVED (21-26)	REASON(27)	SEX (28) 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	AGE (29-30)	(31)	(32)	SPECIMEN: (31) <input type="checkbox"/> Sputum <input type="checkbox"/> Gastric <input type="checkbox"/> Urine <input type="checkbox"/> Bronchial Wash <input type="checkbox"/> Fluid..... <input type="checkbox"/> Tissue..... <input type="checkbox"/> Other Source.....	
PATIENT'S NAME (Last) (First) (Initial)						Comments:.....	
ADDRESS		CITY		ZIP CODE			
MAIL RESULTS TO: →							
ADDRESS: →							
CITY: →				STATE WA	ZIP CODE		
		AREA CODE AND PHONE NO. ()				REFERENCE CULTURE ONLY Source Date Inoc	

(DO NOT WRITE BELOW THIS LINE)

MICROSCOPIC REPORT (Culture results to follow)		CULTURE REPORT	
40	1 <input type="checkbox"/> Unsatisfactory	1 <input type="checkbox"/> Unsatisfactory	41
	2 <input type="checkbox"/> Not Found	2 <input type="checkbox"/> Negative at 8 weeks	
	8 <input type="checkbox"/> AFB Found (reference culture only)	<input type="checkbox"/> Acid-fast bacilli present _____ Date	
	<input type="checkbox"/> Found..... per.....	Comments (54): _____	
Comments (53): _____			
.....			
.....			
.....			
.....			
.....			
.....			
Date			
Tested By:		Tested By:	
Unit Head:		Unit Head:	

DATE OF FINAL REPORT (75-80)